Please fill out this form and send by email to mail.accordsmedicaux@airfrance.fr

INFORMATION SHEET FOR PASSENGERS REQUIRING ASSISTANCE

PART 1 (TO BE FILLED IN BY PASSENGER OR LEGAL GUARDIAN)

1. Patient's name _____

Date of birth *(dd/mm/yyyy)* _____ Gender _____ Nationality _____

Height (meters) _____ Weight (KG) _____

2. Booking reference (PNR) _____

3. Flight details _____ Date _____ *(dd/mm/yyyy)*

Airline(s), flight number(s) _____

4. Will the passenger be escorted ☐ Yes ☐ No

Medical qualification ☐ Yes ☐ No If yes, what qualification? _____

Name _____ Date of Birth _____ *(dd/mm/yyyy)*

PNR if different _____ Nationality _____

5. Medical condition _____

6. Wheelchair needed ☐ Yes ☐ No

Wheelchair categories* ☐ WCHR ☐ WCHS ☐ WCHC Own wheelchair ☐ Yes ☐ No

* WCHR = passenger cannot walk well, but can use stairs
WCHS = passenger cannot walk up- and down stairs
WCHC = passenger cannot walk at all

7. Stretcher needed on board ☐ Yes ☐ No

8. Ambulance needed on embarking and disembarking station ☐ Yes ☐ No

Name ambulance company embarking station _____

Phonenumber ambulance company embarking station _____

Name ambulance company transit station (if applicable) _____

Phonenumber ambulance company transit station (if applicable) _____

Name ambulance company disembarking station _____

Phonenumber ambulance company disembarking station _____

9. Inflight arrangements needed ☐ Yes ☐ No

If yes, specify type of arrangements (e.g. extra seat, legrest) _____

Specify equipment (respirator, incubator, oxygen, etc) _____

10. FREMEC (Frequent traveler Medical Card)

or Saphir Card ☐ Yes ☐ No Nr. _____

Expiry date _____ *(dd/mm/yyyy)*

11. Data protection and Privacy Consent Declaration

The personal and medical details you provide on this form will be used by Air France/KLM to handle your request for medical clearance and to arrange the necessary assistance for your travel arrangements. In order to asses and manage your request, and in order to arrange for the appropriate assistance, care and equipment, it may be necessary for Air France/KLM to process and/or disclose your personal and/or medical information to other airlines in your itinerary and to third parties, such as medical professionals, airport and airline staff, service providers, government bodies and border control authorities.

You should read Air France/KLM's privacy policy for further information and for the contact details of the data protection officer.
https://www.klm.com/travel/nl_nl/customer_support/privacy_policy/privacy_policy.htm
https://www.airfrance.fr/FR/en/common/transverse/footer/edito_psc.htm

☐ *I hereby consent to my personal and/or medical data being processed, used and/or disclosed for the purposes set out above.*

[Date and place] (dd/mm/yyyy) *[Passenger name/signature or Legal guardian name/signature]*

PART 2 (TO BE COMPLETED OR OBTAINTED IN ENGLISH FROM THE ATTENDING PHYSICIAN), PLEASE GO TO THE NEXT PAGE

INFORMATION SHEET FOR PASSENGERS REQUIRING MEDICAL CLEARANCE

1. Diagnosis (including date of onset of current illness, episode or accident and treatment, specify if contagious):

_____

_____

Nature and date of any recent and/or relevant surgery _____

_____

_____

2. Current symptoms and severity _____

3. Additional clinical information

a. Normal bladder control ☐ Yes ☐ No If no, give mode of control _____

b. Normal bowel control ☐ Yes ☐ No If no, give mode of control _____

c. Anemia ☐ Yes ☐ No If yes, give recent result _____ mmol/l or _____ g/100ml of hemoglobin

4. Will a 25% to 30% reduction in the ambient partial pressure of oxygen (relative hypoxia) affect the passenger's medical condition? (Cabin pressure to be the equivalent of a fast trip to a mountain elevation of 2400 meters (8000 feet) above sea level)

☐ Yes ☐ No ☐ Not sure

5. Oxygen needed in flight

a. Oxygen needed in flight? ☐ Yes ☐ No If yes, complete O_2 rate l/min (on-demand)

☐ 1,2 ☐ 2,0 ☐ 2,8 ☐ 3,6 ☐ 4,4 ☐ 5,2

b. ☐ For whole flight ☐ For stand-by

c. Is the patient familiar with the Air France-KLM oxygen system (Wenoll WS120) ☐ Yes ☐ No

(Please note on-demand system not possible for children under 8 years/patients with tracheotomy and very weak passengers. If applicable please contact Air France-KLM directly)

d. Does the patient use oxygen at home? ☐ Yes ☐ No If yes, specify how much l/min _____

e. Has the patient an own O_2 concentrator on board or CPAP

☐ Yes ☐ No If yes, specify brand name _____

f. Will the patient use this own O_2 concentrator or CPAP on board ☐ Yes ☐ No

- Is it battery operated? ☐ Yes ☐ No

g. Please specify Saturation on room air _____ Date of exam *(dd/mm/yyyy)* _____

h. Please specify saturation with oxygen supplies _____ on _____ l/min

6. Cardiac condition ☐ Yes ☐ No If no, please go to question 7

a. Angina ☐ Yes ☐ No When was last episode? *(dd/mm/yyyy)* _____

- Is the condition stable? ☐ Yes ☐ No
- Functional class of the patient? ☐ No symptoms ☐ Angina on heavy exertion/activities ☐ Angina on light exertion/activities ☐ Angina even at rest
- Can the patient walk 100 meters at a normal pace or climb 10 -12 stairs without symptoms?

☐ Yes ☐ No

b. Myocardial infarction ☐ Yes ☐ No Date *(dd/mm/yyyy)* _____

- Complications? ☐ Yes ☐ No If yes, give details _____
- Stress EKG done? ☐ Yes ☐ No If yes, what was the result? Metz _____
- If angioplasty or coronary bypass, can the patient walk 100 meters at normal pace or climb 10–12 stairs without symptoms?

☐ Yes ☐ No

c. Cardiac failure ☐ Yes ☐ No When was last episode? _____

- Is the patient controlled with medication? ☐ Yes ☐ No
- Functional class of the patient (NYHA classification)
  - ☐ No symptoms and no limitations
  - ☐ Mild symptoms and slight limitations
  - ☐ Extreme symptoms and marked limitations
  - ☐ Symptoms even at rest and severe limitations
- Is there a known heart ejection fraction? ☐ Yes ☐ No If yes, give percentage _____ %

d. Syncope ☐ Yes ☐ No When was last episode? _____

- Investigations ☐ Yes ☐ No If yes, state results _____

7. Pulmonary condition ☐ Yes ☐ No If no, please go to question 8

a. Does the patient retain CO_2? ☐ Yes ☐ No

b. Has the patient's condition deteriorated recently?

☐ Yes ☐ No

c. Can the patient walk 100 meters at a normal pace or climb 10 -12 stairs without symptoms?

☐ Yes ☐ No

d. Has the patient ever taken a commercial aircraft in these same conditions?

☐ Yes ☐ No

- If yes when? _____
- Did the patient have any problems? _____

8. Psychiatric or seizure disorder ☐ Yes ☐ No If no, please go to question 9

a. Is there a possibility that the patient will become agitated during a flight?

☐ Yes ☐ No

b. Has he/she taken a commercial flight before?

☐ Yes ☐ No

- If yes, date of travel? *(dd/mm/yyyy)* _____

Did the patient travel alone or escorted? ☐ Alone ☐ Escorted

c. Seizure ☐ Yes ☐ No

1. What type of seizures? _____
2. Frequency of the seizures? _____
3. When was the last seizure? _____
4. Are the seizures controlled by medication? ☐ Yes ☐ No

9. Escort

a. Is the patient fit to travel unaccompanied? ☐ Yes ☐ No

b. If no, will the patient have a private escort to take care of his/her needs onboard? ☐ Yes ☐ No

c. If yes, who should escort the passenger? ☐ Doctor ☐ Nurse ☐ Other _____

d. If other, is the escort fully capable to attend to all needs on board? ☐ Yes ☐ No

10. Mobility

a. Able to walk without assistance? ☐ Yes ☐ No

b. Wheelchair required for boarding to aircraft? ☐ Yes ☐ No

c. Can the patient sit upright in a normal aircraft seat? ☐ Yes ☐ No
(if the answer is NO a stretcher will be required)

11. Medication list

_____

_____

_____

_____

_____

12. Other medical information

_____

_____

_____

_____

_____

13. Prognosis for the trip ☐ Good ☐ Poor

Note: Cabin attendants are not authorized to give assistance to particular passengers, they are trained only in first aid and are not permitted to administer any injection, to give medication, or to feed and toilet patient.

Important: Fees, if any, relevant to the provision of the above information and for carrier-provided equipment are to be paid by the passenger concerned.

Filled and signed

Physician name _____ Date *(dd/mm/yyyy)* _____

Address / Hospital _____

Phone number _____

Email address _____

_____ _____

Stamp doctor/hospital (optional) (Digital) signature

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